



Strong Families Make a Strong Kansas

Out of Home Relative Provider Enrollment

Thank you for your interest in becoming a DCF child care provider for related families who may be eligible for DCF Child Care Assistance. As a relative, you are not regulated by the Kansas Department of Health and Environment (KDHE). DCF must take certain steps in order to ensure the health and safety of the children in your care who are funded through the Child Care Assistance Program. Parent participation is required to complete this enrollment. A relative provider must have a checking account, savings account or pre-paid debit card to receive EBT payments from parents who receive DCF subsidies. Prior to completing the enrollment, read and make sure you understand the DCF Child Care Provider Handbook.

Please return completed enrollment to: _____

Please return by: _____

Note: As an Out-of-Home Relative child care provider, you are enrolling to provide care for the children in one specific family. To provide care for any other children would require a separate enrollment.

DCF OUT OF HOME RELATIVE PROVIDER APPLICATION

Section 1:

Provider Information:

Name (first, middle, last): _____

SSN: _____ Date of Birth: _____ Gender: _____

Race: _____ Hispanic/Latino? _____

Are you a high school graduate or do you have a GED? _____

Primary Language Spoken: _____ Written: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____

County: _____ State: _____ Zip: _____

Primary Telephone Number: _____ Alternate Telephone Number: _____

Email Address: _____

Parent of children for whom you will be caring:

Name of Child's Parent/Guardian: _____ Parent's SSN: _____

Parent's Primary Languages Spoken: _____ Written: _____

Provider Relationship to Children: _____ Date Care Began: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____

County: _____ State: _____ Zip: _____

Primary Telephone Number: _____ Alternate Telephone Number: _____

Email Address: _____

Children for whom you will be caring:

Child Name	Date Care Began	Times of Care

Background Check: DCF records are checked for any history of child abuse or neglect. DCF checks the name(s) of the out of home relative provider and all household members ten (10) years of age or older. Each name must be cleared before approval for payment begins. A provider is not eligible to be approved if the names of any of the persons living in their home appear in either the Child Abuse-Neglect Registry or the Kansas Adult Supervised Population Electronic Repository (KASPER), or if he or she has felony convictions.

List all persons living in your household, including yourself:

Last Name	First Name	Middle Name	Maiden Name	Aliases	SSN	Date of Birth	Role (Relationship to Provider)

Has anyone who lives, works or volunteers in your home/facility been convicted of a felony? _____

If yes, provide name of person, date and court of action, county and state: _____

Please go to the next page for statement review and signature.

